WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-A)

CERTIFICATE OF DEATH

03829

Reg. Dist. No. 18-

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 605 Ontario
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Clarence James Abbott

3.(b) Social Security Number —

4. Sex	5. Color or race	6. If single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 5 - 1902

8. AGE: Years	Months	Days	If less than one day
43	8	5	..... hrs. ..... min.

9. Birthplace Havre de Grace (Town, county, and state)
10. Usual occupation Chauffeur
11. Industry or business —
12. FATHER — Name Martin F. Abbott
13. FATHER — Birthplace Pennsylvania
14. MOTHER — Maiden name Catherine McNulty
15. MOTHER — Birthplace Havre de Grace
16. Informant Gladys Abbott
Address 605 Ontario St., Havre de Grace
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/15/46 (month) (day) (year)
Cemetery or crematory Mt. Erin
Location Havre de Grace
18. Funeral director Pennington & Son
Address Havre de Grace
19. Apr. 14 1946 (Date rec'd by registrar) C. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 1946, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 11 1946, to April 11 1946 and that I last saw h alive on April 11 1946

Immediate cause of death	DURATION
Cerebral hemorrhage	1 Day
Due to Chronic Interstitial Nephritis	5 yrs
Due to Arteriosclerosis	5 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M.D. M. D. or other
Address Havre de Grace Md. Date signed 4/13/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

03830

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:
County: Harford
City or town: Mountain Road
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Mountain Road
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Alice C Airhart

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife: John F Airhart
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): ✓ 1868

8. AGE: Years: 78 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Harford Co (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER
12. Name: Chas Christy
13. Birthplace: Harford Co, Md

MOTHER
14. Maiden name: Dinker
15. Birthplace: Md

16. Informant: Joseph Cole
Address: Bel Air, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 29/46 (month) (day) (year)
Cemetery or crematory: Union Chapel
Location: Wilna, Md
18. Funeral director: Dean & Foster
Address: Bel Air Md

19. 4/29 1946 Priscilla Forwood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26 1946, at 9 45 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1 1940, to April 26 1946
and that I last saw h.. or alive on April 26 1946

Immediate cause of death	DURATION
Arteriosclerotic C V disease	6 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Gerald C. Palmer M.D. M. D. or other
Address: Bel Air, Md. Date signed: 4/29/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (49a) 4

CERTIFICATE OF DEATH

03831

Reg. Dist. No. 18 S-

1. PLACE OF DEATH:
County Harford
City or town Havre De Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Harford Memorial Hospital
How long in hospital or institution? 4 mo. + 15 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. Post Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Bullock

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife William Monson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 6 - 1888

8. AGE: Years	Months	Days	If less than one day
58	1	12	..... hrs. ..... min.

9. Birthplace Pennsylvania Pa
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Isaac Bullock
13. Birthplace Pennsylvania
MOTHER 14. Maiden name Anna M. Walters
15. Birthplace Pennsylvania
16. Informant Charles Bullock
Address Conowingo St
17. Burial Date thereof 4/21/46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Angel Hill
Location Havre de Grace
18. Funeral director Pennington & Son
Address Havre de Grace
19. Apr. 21 1946 C. L. Levin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/18 1946 at 9:15 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/8 1946 to 4/18 1946
and that I last saw h[illegible] alive on 4/17 1946

Immediate cause of death	DURATION
Heart failure	1 wk
Due to Generalized Metastatic	D
Due to Carcinoma	
Other conditions Ca. of Cervix Uteri	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Dudley Phillips M.D.
M. D. or other
Address Harford Memorial Hosp. Date signed 4/20/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03832

Reg. Diat. No. 1-82

1. PLACE OF DEATH

County: Harford

City or town: Forest Hill (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 73 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Harford

City or town: Forest Hill (rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Wm Blair Campbell

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 30 1872

8. AGE: Years	Months	Days	If less than one day
73	5	26	..... hrs. ..... min.

9. Birthplace: Forest Hill Harford Co. Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: James A Campbell

FATHER — 13. Birthplace: Chrome Hill Harford Co. Md

MOTHER — 14. Maiden name: Margaret E. Hazelett

MOTHER — 15. Birthplace: Chrome Hill Md.

16. Informant: Mrs Dora Campbell

Address: Forest Hill Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 28 1946 (month) (day) (year)

Cemetery or crematory: Wm Watters Memorial

Location: Cooptown Harford Co. Md.

18. Funeral director: Marion E Keech

Address: Jarrettsville Md.

19. 4/27 1946 Priscilla Forwood

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 25 1946 at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 2 1946 to April 25 1946 and that I last saw h... alive on April 22 1946

Immediate cause of death	DURATION
Carcinoma of Colon	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Willard R. Hudson M. D. or other

Address: Forest Hill Md Date signed 4/27/46

VS A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (mo-c)

CERTIFICATE OF DEATH

03833

Reg. Dist. No. 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Harford

City or town: Aberdeen, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Tennessee County:

City or town: Coker Creek
(If outside city or town limits, write RURAL and give nearest town)

Street No.: General Delivery
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

Ulys P. Cathey 44 122 015

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 14, 1924

8. AGE: Years	Months	Days	If less than one day
21	9	18	hrs. min.

9. Birthplace: Cherokee County, North Carolina
(Town, county, and state)

10. Usual occupation: Soldier

11. Industry or business: U. S. Army

FATHER 12. Name: Deceased

13. Birthplace:

MOTHER 14. Maiden name: Ethel West Cathey

15. Birthplace:

16. Informant: U.S. Army Records

Address: Aberdeen Proving Ground Md

17. Transportation (Burial, cremation, or removal. Which?) Date thereof: Apr. 5 1946 (month) (day) (year)

Cemetery or crematory: Bradley Funeral Home

Location: Madisonville, Texas

18. Funeral director: Howard K. McInnis

Address: Abingdon Md

19. Apr. 10 1946 (Date rec'd by registrar) Nellie H. Riley Registrar

I certify that I have received the remains of the above in good condition

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 April 1946, at 5:50 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 April 1946 to 3 April 1946 and that I last saw him alive on 3 April 1946

Immediate cause of death	DURATION
1- Contused, lacerated brain,	
2- Sub arachnoid hemorrhages, generalized,	
3- Subdural hemorrhage, massive over motor area, A. right lobe, b. left lobe	
Due to trauma.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Above findings.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 2 April 1946

Where did injury occur? Bet. Havre de Grace & Aberdeen, Harford County, Maryland (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Highway

Means of injury: Auto. accident Injured at work? No

23. SIGNATURE: F. K. Nichols
F. K. NICHOLS, LT COL, MC M. D. or other

Address: Station Hospital, APG, Md. Date signed: 4 Apr 1946

CITIES INCORPORATED LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

03834

Reg. Dist. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 51 years
Hospital, institution, or street address where death occurred:
—
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 514 Young St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Arthur Collins

3.(b) Social Security Number 212-16-5143

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife Sylvia V. Collins
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) March 30, 1895

8. AGE: Years	Months	Days	If less than one day
51	X	20	— hrs. — min.

9. Birthplace Havre de Grace, Harford, Md. (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name Geo. Raymond Collins
13. Birthplace Maryland

MOTHER
14. Maiden name Elisha Wheyte
15. Birthplace Havre de Grace, Maryland

16. Informant Mrs Sylvia Collins
Address 514 Young St. Havre de Grace, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/24/46 (month) (day) (year)
Cemetery or crematory St. James Cemetery
Location Havre de Grace, Md
18. Funeral director Elmer E. Bullock
Address 556 Lewis St. Havre de Grace

19. Apr. 23 1946 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/20 1946, at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1946, to April 24, 1946
and that I last saw h— alive on April 20 1946

Immediate cause of death	DURATION
Arteria Sclerosis	
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions Tobacco	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Charles Foley M.D.
M. D. or other
Address Havre de Grace Date signed 4-23-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03835

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace, Maryland (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Tennessee County:
City or town: Boyds Creek
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Route # 2
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Melvin Lee Crain 44 123 847

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Webb Crain
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 25, 1923

8. AGE: Years	Months	Days	If less than one day
22	9	8	hrs. min.

9. Birthplace: Madisonville, Tennessee
(Town, county, and state)

10. Usual occupation: —

11. Industry or business

FATHER
12. Name: —
13. Birthplace: —

MOTHER
14. Maiden name: Sara Jane
15. Birthplace: —

16. Informant: U.S. Army Records
Address: Aberdeen Proving Ground Md

17. Transportation (Burial, cremation, or removal. Which?) Date thereof: Apr 4 1946 (month) (day) (year)
Cemetery or crematory: Evans Funeral Home
Location: Athens, Tenn.

18. Funeral director: Howard K. McCormson
Address: Abingdon Maryland

19. Apr. 6 1946 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2 19 46, at 240 AM PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Fracture Skull	Instant
Fracture R. Femur	Instant
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 1946
Accident, suicide, or homicide: Accident Date of: April 2
Where did injury occur? Aberdeen, Harford, Maryland
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Highway
Means of injury: Hit by Auto Injured at work? No

Gerald C. Palmer M.D.

23. SIGNATURE: GERALD C. PALMER, M.D.
M. D. or other
Address: Bel Air, Harford County, Md. Date signed: 4/2/46

I certify that I have received the remains of the above in good condition

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03836

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No. 121 East Bond
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles Eustace

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Adelia Eustace
6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): July 11, 1870

8. AGE: Years	Months	Days	If less than one day
75	8	21	hrs. min.

9. Birthplace: Ireland (Town, county, and state)
10. Usual occupation: retired
11. Industry or business

FATHER
12. Name: Charles Eustace
13. Birthplace: Ireland

MOTHER
14. Maiden name: Nora Killeen
15. Birthplace: Ireland

16. Informant: Son - John J. Eustace
Address: Aberdeen, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 4-1946 (month) (day) (year)
Cemetery or crematory: St Francis
Location: Abingdon
18. Funeral director: Hanway Farring Sons
Address: Aberdeen Md.

19. Apr. 2 1946 A. L. Lewis M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 1 1946, at 11:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 3 1946, to April 1 1946, and that I last saw him alive on April 1 1946.

Immediate cause of death	DURATION
Carcinoma Stomach	
Due to	
Due to: Cachexia	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Charles J. Foley M.D. M.D. or other
Address: Havre de Grace Date signed: 4/2/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

03837

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:
County Harford
~~City or~~ town Darlington
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 93
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Harford
~~City or~~ town Darlington
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION) R5
2.(a) If veteran, name war

3.(a) FULL NAME Wm. E. Gallion

3.(b) Social Security Number No

4. Sex	5. Color or race	6.(a) Single, married, widowed, ~~or divorced~~
Male	White	Widower

6.(b) Name of husband or wife: Mary Gallion Dead
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 7, 1852

8. AGE: Years	Months	Days	If less than one day
93	5	19	..... hrs. ..... min.

8. Birthplace: Harford Co. Md.
(Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business:
FATHER 12. Name: Robert Gallion
FATHER 13. Birthplace: Harford Co. Md.
MOTHER 14. Maiden name: Unity Glenn
MOTHER 15. Birthplace: Harford Co. Md.
16. Informant: Dr. Wm. E. Gallion
Address: Darlington, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 28 1946 (month) (day) (year)
Cemetery ~~or crematory~~: Dublin Cem.
Location: Harford Co. Md.
18. Funeral director: H. S. Bailey
Address: Darlington, Md.
19. April 27 1946 (Date rec'd by registrar) M. K. Kirk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1946 at 4:20 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 1 1946 to April 26 1946 and that I last saw him alive on April 26 1946

Immediate cause of death	DURATION
Cerebral hemorrhage	1 yr
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE W. E. Gallion M. D. or other
Address Darlington Date signed 4-26-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

03838

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 75-C

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: 624 So. Washington St.
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Havre de Grace Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 624 S. Washington St.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Sallie P. Galloway

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Feb. 3, 1857

8. AGE:

Years	Months	Days	If less than one day
89	2	22	— hrs. — min.

9. Birthplace: Harford Co. Md. (Town, county, and state)
10. Usual occupation: School Teacher
11. Industry or business: Retired

FATHER
12. Name: Moses Galloway
13. Birthplace: Md.

MOTHER
14. Maiden name: Henritta Brown
15. Birthplace: Md.

16. Informant: Miss Rosa Belle Galloway
Address: Havre de Grace, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 27 1946 (month) (day) (year)
Cemetery or crematory: Angel Hill
Location: Havre de Grace, Md.

18. Funeral director: T. Madison McTilell
Address: Havre de Grace, Md.

19. Apr. 26 1946 (Date rec'd by registrar) C. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 25 1946 at 4 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 24 1946, to Apr. 25 1946 and that I last saw her alive on Apr. 24 1946

Immediate cause of death	DURATION
Cardiac Decompensation	
Due to Old Age	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. L. Lewis M.D. M. D. or other
Address: Havre de Grace, Md. Date signed 4-26-46

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

03839

Reg. Dist. No. 185

1. PLACE OF DEATH

County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, institution, or street address where death occurred:

—

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. Commerce & Market

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Bernard Giddings

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Florence C Giddings

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 30-1882?

8. AGE: Years	Months	Days	If less than one day
64?	10	2	....hrs. ....min.

9. Birthplace Howard Co. Md.

(Town, county, and state)

10. Usual occupation Fireman

11. Industry or business —

FATHER 12. Name Geo. W. Giddings

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Leanna Cross

MOTHER 15. Birthplace Howard Co. Md.

16. Informant Geo. W. Giddings Jr.

Address Laurel, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/2/46 (month) (day) (year)

Cemetery or crematory Emanuel

Location Daggsville, Md.

18. Funeral director DeWitt Donaldson

Address Laurel Md.

19. Apr. 30 1946 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 1946 at 3P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Gerald C. Palmer M D Deputy Medical Examiner M. D. or other

Address Harford County Bel Air, Md. Date signed 4/30/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (41)

CERTIFICATE OF DEATH

★ 03840

Reg. Diat. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 — 4-45-1

1. PLACE OF DEATH:

County: Harford

City or town: Bel-Air (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:
Fountain Green Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Harford

City or town: Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Chestnut Hill
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mattie Ellen Greene

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Wm A Greene

6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Jan 20 1877

8. AGE: Years	Months	Days	If less than one day
69	2	13	...hrs. ...min.

9. Birthplace: Ashe Co. North Carolina
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: —

FATHER
12. Name: F. P. Caudill
13. Birthplace: North Carolina

MOTHER
14. Maiden name: Caroline Fender
15. Birthplace: North Carolina

16. Informant: Wm A Greene
Address: Forest Hill Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 5 - 46 (month) (day) (year)

Cemetery or crematory: Mt Zion

Location: Fountain Green, Harford Co. Md.

18. Funeral director: Martin E Rust.

Address: Fawnstville Md.

19. 4/3 1946 (Date rec'd by registrar) Priscilla Forwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 2 1946, at 11:50 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 1 1945, to April 2 1946 and that I last saw her alive on April 2 1946

Immediate cause of death	DURATION
Acute Broncho-pneumonia	
Secondary to Influenza	
Due to: Respiratory Infection	5 da.
Chr. Myocardial Degen.	2yrs
Due to:	
Other conditions: Diabetes Mellitus	?

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Willard P. Hedgson M.D. or other

Address: Forest Hill Md Date signed: 4/3/46

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

CERTIFICATE OF DEATH

03841

Reg. Dist. No. 18-5

1. PLACE OF DEATH:

County Harford

City or town Havre de Grace, Maryland (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Virginia County

City or town Red Ash
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James Oliver Hill

3.(b) Social Security Number 43 000 691

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mrs. Martha Louise Hill

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22, 1923

8. AGE: Years	Months	Days	If less than one day
22	11	9	hrs. min.

9. Birthplace Red Ash, Virginia
(Town, county, and state)

10. Usual occupation —

11. Industry or business

FATHER 12. Name James Jackson Hill

13. Birthplace —

MOTHER 14. Maiden name Deceased

15. Birthplace

16. Informant U.S. Army Records

Address Aberdeen Proving grounds Md

17. Transportation Date thereof Apr 3 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Richlands Funeral Home

Location Richlands Virginia

18. Funeral director Howard K. McCormack

Address Abingdon Maryland

19. Apr. 6 1946 A. L. Lewis M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

AM

20. DATE OF DEATH April 2 1946 at 310 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Fracture Skull	30 min
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 1946

Accident, suicide, or homicide Accident Date of April 2

Where did injury occur? Aberdeen (City or town) Harford (County) Maryland (State)

Injured at home, farm, industry, public place (where?) Highway

Means of injury Hit by Auto Injured at work? No

Gerald C Palmer M.D.

23. SIGNATURE GERALD C. PALMER, M.D. M. D. or other

Address Belair, Harford, County, Md Date signed 4/7/46

I certify that I have received the ... ains of the above ... good condition

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

03842

Reg. Diat. No. 180

1. PLACE OF DEATH:

County Harford

City or town Churchville Bel Air R.D

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Calvary

(If outside city or town limits, write RURAL and give nearest town)

Street No. Aberdeen R.D. —

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William N. Hoffman

3. (b) Social Security Number 217-26-5929

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... yeare

7. Birth date of deceased (mo., day, yr.) June 27 1924

8. AGE: Years	Months	Days	If lese than one day
21	9	24	..... hrs. ..... min.

9. Birthplace Calvary Aberdeen R.D. (Town, County, and state)

10. Usual occupation Clerk

11. Industry or busineee

FATHER 12. Name Albert P. Hoffman

FATHER 13. Birthplace Bel Air Md

MOTHER 14. Maiden name Effie Kirtley

MOTHER 15. Birthplace Aberdeen Md

16. Informant Albert P. Hoffman

Address Calvary, Aberdeen R.D. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 24 1946 (month) (day) (year)

Cemetery or crematory Calvary Methodist

Location Calvary Maryland

18. Funeral director Howard K. McCormack

Address Abingdon Maryland

19. Apr 2nd (Date rec'd by registrar) 19 46 Mary M. Mouldsdale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 19 46 at 1A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Fracture Skull	—
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 4/21/46

Where did injury occur? Bel Air Harford Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Highway

Means of injury Auto accident Injured at work? No

23. SIGNATURE Donald E. Palmer M.D. Deputy Medical Examiner

M. D. or other

Address Harford County Date signed 4/21/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

03843

CERTIFICATE OF DEATH

★ Reg. Diat. No. 181

1. PLACE OF DEATH:

County Harford

City or town Rural Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Rural Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

Street No. Calvary

(If rural, give LOCATION)

2.(a) If veteran, name war none

3.(a) FULL NAME Mrs. Margaret Mc Hohlein

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband ~~or wife~~ John S. Hohlein

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 21 - 1865

8. AGE: Years	Months	Days	If less than one day
80	9		..... hrs. ..... min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Buck

13. Birthplace Germany

MOTHER 14. Maiden name Huffman

15. Birthplace Germany

16. Informant Mrs. William Lafuterbach

Address Aberdeen Md. R.F.D. #2

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 16-1946 (month) (day) (year)

Cemetery or crematory Babes

Location Aberdeen Md.

18. Funeral director Henry Tarring & Sons.

Address Aberdeen Md.

19. April 15 1946 Nellie S. Riley

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-12-46 19.... at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-12 19.46., to ..... 19.....

and that I last saw h~~er~~ alive on 4-12-46 19.....

Immediate cause of death Coronary Obstruction — DURATION

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

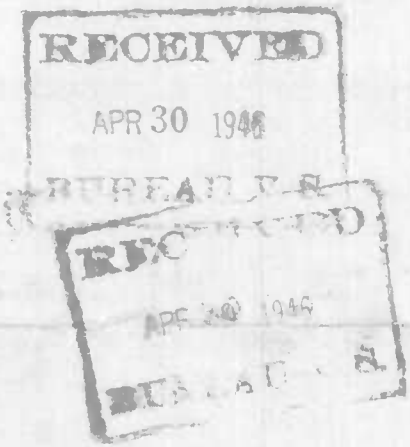
23. SIGNATURE ..... M. D. or other

Address ..... Date signed 4-13-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 . 9-45-1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VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 038448 S-

1. PLACE OF DEATH:

County: Harford

City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mo. 17 Days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)

Street No. 511 Pine st
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME Charlotte Hoke

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 2 - 1945

8. AGE: Years	Months	Days	If less than one day
	6	17	..... hrs. ..... min.

9. Birthplace: Havre de Grace Harford
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: Louis L. Hoke

13. Birthplace: Germany

MOTHER 14. Maiden name: Margaret Smith

15. Birthplace: Havre de Grace

16. Informant: Mrs. Louis L. Hoke

Address: 511 Pine st. Havre de Grace

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 20, 1946 (month) (day) (year)

Cemetery or crematory: Union M. E.

Location: Near Aberdeen Md

18. Funeral director: Henry Tapping & Sons

Address: Aberdeen, Md

19. Apr. 20 1946 (Date rec'd by registrar) C. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 18 1946, at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 17, 1946, to April 18 1946, and that I last saw h... alive on April 18 1946.

	DURATION
Immediate cause of death: Influenza	
Due to: Pneumonia	
Due to: Fever	
Due to:	
Other conditions: Toxemia	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Charles J. Staley M.D. (M. D. or other)

Address: Havre de Grace Md. Date signed: 4/20/46

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

03845

Reg. Dist. No. 185

1. PLACE OF DEATH:

County Harford

City or town Havre de Grace Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Harford Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Harford

City or town Aberdeen, Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. R. F. D. #1
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Walter Irvin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Leanner Irvin

6.(c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) July 27, 1901

8. AGE: Years 44 | Months 9 | Days 7 | If less than one day ... hrs. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Walter Irvin

13. Birthplace Maryland

MOTHER 14. Maiden name Pillabelle Jackson

15. Birthplace Maryland

16. Informant Leanner Irvin - Wife

Address R. F. D. #1 - Aberdeen, Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof Apr. 7 1946 (month) (day) (year)

Cemetery or crematory Wesleyn. Cem.

Location Aberdeen Md R.D.

18. Funeral director Hubert P. Hankins

Address Delta, Pa.

19. Apr. 4 1946 (Date rec'd by registrar) C. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4 1946, at 6.25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1942, to Apr 4 1946

and that I last saw him alive on Apr 3 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Hypertensive cardio-vascular disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G B Jastram MD
M. D. or other

Address Aberdeen, Md. Date signed 4-4-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

03846

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH:
County: Harford
City or town: Rural Havre de Grace R.D.#1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, institution, or street address where death occurred: Rural Havre de Grace Md. R.D. #1
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Rural Havre de Grace R.D. #1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Hulda Moyer Lebo

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Jacob Lebo
6.(c) If alive, give age: — years
7. Birth date of deceased (mo., day, yr.): Jan. 25, 1856

8. AGE: Years	Months	Days	If less than one day
90	2	17	— hrs. — min.

9. Birthplace: Penn
(Town, county, and state)
10. Usual occupation: House Duties
11. Industry or business: Self

MOTHER
12. Name: Wm McCorkle
13. Birthplace: Penn.

FATHER
14. Maiden name: Mary Hamilton
15. Birthplace: Penn.

16. Informant: Mrs. Mary Susan Rase
Address: Havre de Grace R.D #1 Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 15, 1946 (month) (day) (year)
Cemetery or crematory: Odd Fellows Cem.
Location: Tamaqua, Schuylkill Co., Pa.
18. Funeral director: R. Madison Mitchell
Address: Havre de Grace, Md.
19. April 13, 1946 (Date rec'd by registrar) Nellie A. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11, 1946, at 7:05 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..., 19..., to Apr. 11, 1946
and that I last saw h[er] alive on Apr. 11, 1946

Immediate cause of death	DURATION
Pulmonary Oedema	1 day
Due to Myocarditis (Chronic)	10 yrs
Due to Arteriosclerosis	40 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Fred Wolbeck M.D.
M. D. or other
Address: Havre de Grace Date signed: 4/12/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (42) 4

CERTIFICATE OF DEATH

03847

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Harford
City or town Bel air Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Harford
City or town Bel air
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Charles Mc Carthy

3.(b) Social Security Number 212-14-3265

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Annie E. Macarthy
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1872

8. AGE: Years	Months	Days	If less than one day
74	2	11	..... hrs. ..... min.

9. Birthplace Baltimore Co. Md (Town, county, and state)
10. Usual occupation Retired Farmer
11. Industry or business

FATHER
12. Name Owen Mc Carthy
13. Birthplace Ireland

MOTHER
14. Maiden name Mary Campion
15. Birthplace Ireland

16. Informant Miss Ruth M. Mc Carthy
Address Bel air Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr 24 1946 (month) (day) (year)
Cemetery or crematory Long Green
Location Long Green Balto Co. Md.

18. Funeral director Howard K. McComas Son
Address Abingdon Maryland

19. 4/23 1946 Priscilla Steward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 20 1946, at 8:51 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1946 to April 20 1946 and that I last saw him alive on April 20 1946

Immediate cause of death	DURATION
Carcinoma of Sigmoid Colon	4 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Willard P. Hudson M. D. or other
Address Forest Hill Md Date signed 4/22/46

NAME: statement in person by informant 5-13-46 L

03848

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

Reg. Dist. No. 18-

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution? 7 2 hr.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No. 16 Aberdeen Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME JANET ~~Jeanette~~ Ruth Moore

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 7/22/45

8. AGE: Years | Months: 9 | Days: 3 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: Child

11. Industry or business: Child

FATHER
12. Name: Oscar Moore
13. Birthplace: Tenn.

MOTHER
14. Maiden name: Viola Cooke
15. Birthplace: Iowa, Md.

16. Informant: Oscar Moore
Address: 66 Aberdeen Ave., Aberdeen, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/27/46 (month) (day) (year)
Cemetery or crematory: Angel Hill
Location: Havre de Grace

18. Funeral director: Pennington & Son
Address: Havre de Grace Md.

19. Apr. 26 1946 (Date rec'd by registrar) G. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26 1946, at 10 55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 25 1946 to April 26 1946 and that I last saw h... alive on April 26 1946

Immediate cause of death	DURATION
Bronchopneumonia	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Dudley Phillips M. D. or other
Address: Harford Memorial Hosp. Date signed 4/26/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (16-a)

03851

CERTIFICATE OF DEATH

Reg. Diat. No. 180

1. PLACE OF DEATH:
County: Harford
City or town: Edgewood Arsenal, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Edgewood Arsenal, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: JAMES ALEXANDER NORRIS (Infant)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

8.(b) Name of husband (Father) James Frank Norris
8.(c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.): 18 February 1946

8. AGE: Years	Months	Days	If less than one day
	1	15	hrs. min.

9. Birthplace: Edgewood Arsenal, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: James Frank Norris
13. Birthplace: New York City

MOTHER — 14. Maiden name: Rita Marie Norris
15. Birthplace: Albany, New York

16. Informant: James F. Norris
Address: Edgewood Arsenal, Maryland

17. Interment (Burial, cremation, or removal. Which?) Date thereof: Apr 3 1946 (month) (day) (year)
Cemetery or crematory: Walter B. Cook, Inc.
Location: 1 W. 190th St New York City

18. Funeral director: Howard K. McCorkindale
Address: Abingdon Md

19. April 3 1946 (Date rec'd by registrar) Maire M. Mardale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2 April 1946, at 8:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from did not attend 19 to 19
and that I last saw h alive on not seen 19

Immediate cause of death	DURATION
asphyxia and vomiting.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Louis G. Feo, Captain, M. C.
M. D. or other
Address: Station Hospital Edgewood Arsenal, Md. Date signed: 2 Apr 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Name: letter from Dr. Wolbert filmed 6-10-46 G105 - LL showing deceased known as RANDOLPH and also as BANKS due to re-marriage of mother.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

03849

Reg. Diat. No. 181

1. PLACE OF DEATH:
County Harford
City or town Rural - Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Near Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Richard Randolph or RICHARD BANKS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of ~~husband or~~ wife Dorothy Buchanan
6.(c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) Oct. 23rd 1917

8. AGE: Years	Months	Days	If less than one day
28	6		hrs. min.

9. Birthplace Port Deposit Cecil Co., Md. (Town, county, and state)
10. Usual occupation Day Laborer
11. Industry or business

FATHER
12. Name Richard Randolph
13. Birthplace Washington D.C.

MOTHER
14. Maiden name Mabel Tildon
15. Birthplace Port Deposit Md.

16. Informant Mrs. Dorothy Randolph or BANKS
Address Aberdeen, R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 29, 1946 (month) (day) (year)
Cemetery ~~or crematory~~ Mt Calvary
Location Near Aberdeen

18. Funeral director Henry Tarring & Sons
Address Aberdeen Md.

19. Apr. 29 1946 (Date rec'd by registrar) Nellie H. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1946 at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1946 to April 25 1946 and that I last saw him alive on April 25 1946

Immediate cause of death	DURATION
Pulmonary edema	1 day
Due to Chronic Rheumatic Carditis	1 week
Due to Chronic Interstitial Nephritis	2 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank Wolbert M.D. M. D. or other
Address Havre de Grace Md. Date signed April 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

03850

CERTIFICATE OF DEATH

Reg. Diat. No. 183

1. PLACE OF DEATH:

County: Harford

City or town: Rocks (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 38 years

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Harford

City or town: Rocks (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No. —
(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME: William Emerson Rice

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	COL	married

6.(b) Name of husband or wife: Laura Rice

6.(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): Feb 22 1867

8. AGE:

Years	Months	Days	If less than one day
79	1	14	...hrs. ...min.

9. Birthplace: Cooltown Harford Co Md
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: —

FATHER — 12. Name: Wm Rice

13. Birthplace: Harford Co Md.

MOTHER — 14. Maiden name: Maria Bell

15. Birthplace: Harford Co Md.

16. Informant: Gladys Rice

Address: Rocks Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 8-1946 (month) (day) (year)

Cemetery or crematory: Chestnut grove (col)

Location: Rocks, Harford Co Md.

18. Funeral director: Martin Gsurtz.

Address: Jarrettsville Md.

19. Apr. 8 1946 Thomas R Brown
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 5 1946 at 7.30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Last Day of illness only 19... 19...

and that I last saw him alive on April 5 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 hr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: Willard P Hudson M. D. or other

Address: Forest Hill Md Date signed: 4/6/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

03852

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

Reg. Dist. No. 187

1. PLACE OF DEATH:
County: Harford
City or town: Street Rural (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Street Rural (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Oliver O. Scarborough
3.(b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Ida M. Scarborough
6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): March 25, 1873

8. AGE: Years: 73 | Months: 1 | Days: 5 | If less than one day: hrs. min.

9. Birthplace: Harford Co. Md. (Town, county, and state)
10. Usual occupation: merchant
11. Industry or business

FATHER
12. Name: Andrew Scarborough
13. Birthplace: Harford Co. Md.

MOTHER
14. Maiden name: Mittie Scarborough
15. Birthplace: Harford Co. Md.

16. Informant: Ida M. Scarborough
Address: Street, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 2, 1946 (month) (day) (year)
Cemetery or crematory: Slate Ridge cemetery
Location: Delta, Pa.

18. Funeral director: Herbert O. Harkins
Address: Delta, Pa.

19. May 1, 1946 (Date rec'd by registrar) M. W. Kirk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30 1946, at 3 00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1939, to April 30 1946
and that I last saw h. alive on April 29 1946

Immediate cause of death	DURATION
Uremia,	2 wks
Due to Chronic Nephritis	
Due to generalized Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Josiah A. Hunt M.D. M. D. or other
Address: Cardiff, Md. Date signed 4/30/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93e

CERTIFICATE OF DEATH

Reg. Dist. No. 183

1. PLACE OF DEATH:
County: Harford
City or town: Rocks
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 yr
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Rocks (rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Laura Louisa Leggings

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband or wife: Herbert Thomas Leggings
6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): Dec 23, 1880

8. AGE:

Years	Months	Days	If less than one day
65	3	9	...hrs. ...min.

9. Birthplace: Loddon Norfolk England
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Wm Vann
13. Birthplace: England

MOTHER
14. Maiden name: Nannie Vinson
15. Birthplace: England

16. Informant: Herbert T. Leggings
Address: Rocks, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 3, 1946 (month) (day) (year)
Cemetery or crematory: Wm Watters Memorial
Location: Cooktown, Harford Co. Md.
18. Funeral director: Martin G. Klutz
Address: Jarrettsville, Md.

19. April 3 1946 (Date rec'd by registrar) Thomas R. Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 1st 1946, at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 31 1946 to ... 19..
and that I last saw h... alive on March 31 1946

Immediate cause of death	DURATION
pulmonary edema	
Due to myocarditis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Benjamin Dorsey M.D. M. D. or other
Address: Cardiff Md. Date signed 4-3-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03853

CERTIFICATE OF DEATH

Reg. Dist. No. 184

1. PLACE OF DEATH:
County: Harford
City or town: Dublin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Dublin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION) No
2.(a) If veteran, name war

3.(a) FULL NAME: Jacob Snavely

3.(b) Social Security Number: No

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widower
6.(b) Name of husband or wife: Virginia Snavely
Dead
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): June 11, 1857

8. AGE: Years: 88 Months: 9 Days: 20 If less than one day: hrs. min.

9. Birthplace: Wythe Co., Va.
(Town, county, and state)
10. Usual occupation: Retired Merchant
11. Industry or business:
FATHER 12. Name: Aaron Snavely
13. Birthplace: Wythe Co. Va.
MOTHER 14. Maiden name: Harriet E. Pinkerton
15. Birthplace: Wythe Co. Va.
16. Informant: Mrs. Wm. E. James
Address: Street, Md. R.D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 3 1946 (month) (day) (year)
Cemetery or crematory: Darlington Md.
Location: Harford Co. Md.
18. Funeral director: H. S. Bailey
Address: Darlington, Md.
19. April 2 1946 M. H. Kirk
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 1st 1946, at 10 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Mar. 2 1946 to April 1 1946 and that I last saw h... alive on April 1st 1946

Immediate cause of death	DURATION
Coronary Occlusion	4 weeks
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: F. P. Snodgrass M. D. or other
Address: Darlington Date signed: 4/3/46

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03854

CERTIFICATE OF DEATH

FILM No. I 04 MAY 22 1946

Reg. Diat. No. 182

1. PLACE OF DEATH:

County: Harford

City or town: Bel Air Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, institution, or street address where death occurred: Harford Co., Home

How long in hospital or institution? 10 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Rural Bel Air

(If outside city or town limits, write RURAL and give nearest town)

Street No.: County Home

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: William Spradling

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

B.(b) Name of husband or wife: ✓

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feby 16-1870

8. AGE: Years	Months	Days	If less than one day
76 75			..... hrs. ..... min.

9. Birthplace: Balto. Md (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: W^m Spradling

13. Birthplace: ✓

MOTHER — 14. Maiden name: Unknown

15. Birthplace: ✓

16. Informant: Clerk to Superintendent

Address: Bel Air Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 13/46 (month) (day) (year)

Cemetery or crematory: Harford Co Home

Location: Near Bel Air Md

18. Funeral director: Deaver Funeral

Address: Bel Air Md

19. 4/12 1946 (Date rec'd by registrar) Priscilla Fawood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 12 1946, at ..... M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..., to April 12 1946

and that I last saw him alive on April 10 1946

Immediate cause of death	DURATION
Carcimoni of Colon	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other

Address: Forest Hill, Md. Date signed: 4/12/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

03855

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:
County: Harford
City or town: Edgewood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Edgewood
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Ida D. Stevens

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Robert Stevens
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 2, 1867

8. AGE: Years	Months	Days	If less than one day
78	4	5	— hrs. — min.

9. Birthplace: Md (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business:
FATHER 12. Name: Schafer
13. Birthplace: Md.
MOTHER 14. Maiden name: ?
15. Birthplace: ?
16. Informant: Mr Wm Stevens
Address: Edgewood Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 10-46 (month) (day) (year)
Cemetery or crematory: Mt Carmel
Location: Edgewood Md
18. Funeral director: Chas E Foos
Address: Benson, Md
19. 4/8 1946 (Date rec'd by registrar) Priscilla Forwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 7th 1946 at 2 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 20 1945 to April 7th 1946
and that I last saw her alive on April 7th 1946

Immediate cause of death	1.	DURATION 6 mos.
Coronary Thrombosis		
Due to		
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: A. F. Van Tobey M. D. or other
Address: Del Air, Md. Date signed: April 9, 1946

IF THIS CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12)

CERTIFICATE OF DEATH

03856

Reg. Dist. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace Memorial Hospital
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 hr.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Churchville, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George Tenly

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	W

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 22 - 1866

8. AGE: Years 79 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Balto. Co. (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Henry Tenly
13. Birthplace Balto. Co., Md.

MOTHER 14. Maiden name Mary Curry
15. Birthplace Street, Md

18. Informant Mrs Harry Tenly
Address Bel Air, RD. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 15 46 (month) (day) (year)
Cemetery or crematory St Ignatius
Location Hickory, Md

18. Funeral director Deaver & Sons
Address Bel Air Md

19. Apr. 12 1946 (Date rec'd by registrar) C. L. Lewis MD Registrar

MEDICAL CERTIFICATION 46

20. DATE OF DEATH Apr 12 1945, at 3 25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/12 1946, to 4/12 1946 and that I last saw him alive on 4/12 1946

Immediate cause of death	DURATION
Pulmonary Edema	1 hr.
Due to Acute Cardiac Failure	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Dudley Phelps M. D. or other
Address Harford Memorial Hosp Date signed 4/12/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462 4

03857

CERTIFICATE OF DEATH

Reg. Dist. No. 182

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Harford
City or town Bel Air Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 wks
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Howard
City or town Savage
(If outside city or town limits, write RURAL and give nearest town)
Street No. /
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Roberta Lee Wakeman ANNIE ~~WHITMAN~~ **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) May 19 1865

8. AGE: Years	Months	Days	If less than one day
81		29	..... hrs. ..... min.

9. Birthplace Va. (Town, county, and state)
10. Usual occupation Housekeeper
11. Industry or business Home
FATHER 12. Name Morgan Wakeman
13. Birthplace Va.
MOTHER 14. Maiden name Amanda Galloday
15. Birthplace Va.
16. Informant Mrs. Julia Harper Kuck
Address 718 Reservoir St. Balto 17 Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 20 1946 (month) (day) (year)
Cemetery or crematory Meadow Ridge Mem Park
Location Waverly Md.
18. Funeral director Wm. Hill Woodson
Address Laurel Md.
19. 4/19 1946 Priscilla Foxwell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1946 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25 1946 to April 18 1946 and that I last saw h.. alive on April 16 1946

Immediate cause of death	DURATION
Carcinoma of Colon	1½ yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Willard P. Hudson M. D. or other
Address Forest Hill, Md. Date signed 4/18/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03858

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH:
County: Harford
City or town: Aberdeen (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs.
Hospital, Institution, or street address where death occurred:
28 Hanover St
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Aberdeen (If outside city or town limits, write RURAL and give nearest town)
Street No. 28 Hanover St (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Rosia Lee Walker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife: Theodore
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 14, 1916

8. AGE: Years	Months	Days	If less than one day
30	1		hrs. min.

9. Birthplace: Georgia (Town, county, and state)
10. Usual occupation: Day Laborer
11. Industry or business: U. S. Government
FATHER 12. Name: Eddie Bates
13. Birthplace: Georgia
MOTHER 14. Maiden name: Mary Smith
15. Birthplace: Georgia
16. Informant: Mrs. Olevia Draper
Address: 28 Hanover St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 1, 1946 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: Near Aberdeen
18. Funeral director: Henry Tarring & Sons
Address: Aberdeen Md.
19. May 1 19 46 (Date rec'd by registrar) Nellie H. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 28 1946 at 3A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 15 1946 to April 28 1946 and that I last saw h.er alive on April 28 1946

Immediate cause of death	DURATION
Pulmonary Edema	1 day
Due to: Myocardial failure	2 weeks
Due to:	
Other conditions: Pulmonary TBc	6 mos

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Emma Wolcott M.D. M. D. or other
Address: Hanover St Date signed 4/29/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53-d)

CERTIFICATE OF DEATH

03859

Reg. Dist. No. 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. — MARGIN RESERVED FOR BINDING — VS A15

1. PLACE OF DEATH:
County: Harford
City or town: Rural Havre de Grace, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs.
Hospital, Institution, or street address where death occurred: Havre de Grace, Md R.D. #1
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Rural Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. #1
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Wilbur Winfield Walker

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elsie Fulton Walker
6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): Nov. 16, 1891

8. AGE:

Years	Months	Days	If less than one day
54	4	19	..... hrs. ..... min.

9. Birthplace: Harford Co. Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Self

FATHER
12. Name: Winfield Scott Walker
13. Birthplace: Md.

MOTHER
14. Maiden name: Oleita Donahoe
15. Birthplace: Md.

16. Informant: Mrs. Elsie F. Walker
Address: Havre de Grace, Md. R.D.#1

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 7, 1946 (month) (day) (year)
Cemetery or crematory: Wesleyan Chapel
Location: Harford Co. Md.

18. Funeral director: R. Madison Mitchell
Address: Havre de Grace, Md.

19. April 5 1946 Berida B. Knight
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 4 1946, at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1943, to Apr. 4 1946 and that I last saw h— alive on Apr. 3 1946

Immediate cause of death	DURATION
Adeno carcinoma, brain	9 days
Due to: Adeno carcinoma, medullary sinus	2 mos
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: J. Rayder Harley M.D.
M. D. or other
Address: Churchville Md. Date signed: April 5

Evidence for change of age of deceased is shown on FILM No. I 01 MAY - 7 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (99-4)

CERTIFICATE OF DEATH

03860

Reg. Diat. No. 181

1. PLACE OF DEATH:

County Harford

City or town near Aberdeen Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant give residence of mother)

State Maryland County Harford

City or town near Aberdeen Md,
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Olive Josephine Zell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

8.(b) Name of husband or wife David Zell

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 22. 1882

8. AGE: Years	Months	Days	If less than one day
63 ~~64~~	5	9	....hrs. ....min.

9. Birthplace North East Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name William Benjamin

13. Birthplace North East. Maryland

MOTHER 14. Maiden name Josephine Wilson

15. Birthplace Maryland

16. Informant Sarah Jackson

Address Aberdeen Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 4, 1946 (month) (day) (year)

Cemetery or crematory Faemont Pa.

Location near Nottingham, Pa.

18. Funeral director J. E. Tyson.

Address Rising Sun Md.

19. apr 2 - 1946 E M Worthington Deputy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1946 at 1205 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1942 to March 31 1946 and that I last saw h.. alive on March 30 1946

	DURATION
Immediate cause of death Myocardial disease.	
Due to Cerebral Hemorrhage & Epilepsy.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. L. Dodson M.D. M. D. or other

Address Rising Sun Md. Date signed 4-1-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15